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ABSTRACT

Proposals have been developed to clarify physician responsibility in withholding treatment to terminally ill patients. These proposals seek to provide a legal shield against malpractice proceedings and to reduce confusion over how to resolve high medical costs through standardizing procedures for withholding treatment. When first published, withholding treatment guidelines pertained only to patients whose deaths were expected within weeks. The new proposals include hopelessly ill patients, those patients who are irreversibly ill but not clearly dying. Five categories of hopelessly ill patients are: (1) competent patients who refuse treatment; (2) brain-dead patients; (3) persons in persistent vegetative states; (4) severely and irreversably demented persons; and (5) persons with mild dementias who should be treated "sparingly." While the first three categories break no new medical ground, conditions 4 and 5 appear to be outside the scope of approved medical standards of care and several major criticisms of the proposals can be made. Two major questions which should be considered in any public debate over treatment policies to sick elderly persons are the determination of competence in the sick elderly and, where incompetence is present, what is to be the role of families. Perhaps the most important contribution that gerontologists can make to this debate involves insisting on guidelines that enable the sick elderly to control their own futures if they choose to do so. (NB)

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GERONTOLOGY & POLICIES FOR NOT TREATING TERMINALLY ILL PATIENTS

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This paper deals with proposals for withholding treatment* to terminally ill patients as contained in a recent article in the New England Journal of Medicine entitled "Physician Responsibility Toward Hopelessly Ill Patients" (1984).[1] These proposals, developed to "clarify physician responsibility" would, if adopted, create categories of patients who would routinely be denied treatment when classified as "hopelessly ill". This question has come to public attention recently due to publicity about (1) the alleged high cost of dying as well as (2) the indictments of two California physicians who were charged with manslaughter.[2] By clarifying physician responsibility, the proposals under examination (to be referred to as Wanzer et al) seek to erect a legal shield against malpractice proceedings, and at the same time, reduce confusion over how to resolve high medical costs through standardizing procedures for withholding treatment. This paper suggests that gerontologists should examine these and similar proposals since any categories created would contain large numbers of sick elderly whose

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*"Withholding treatment" is used here as a short-hand term to include orders not to resuscitate as well as orders not to begin and/or to terminate treatment modalities that are thought to be medically futile and/or burdensome to patients

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health needs continue to be poorly served by acute-care medicine. Furthermore, it is argued here that when physicians seek legal immunity through legal standards of care, they then take the debate about withholding treatment to a broad public level where gerontologists can and should contribute.

When first published, withholding treatment guidelines pertained only to patients "clearly dying", i.e., whose deaths were expected within several weeks.[3] This question of when death is reasonably expected is critical since the Wanzer et al proposals seem to take the concept of "terminally ill" and enlarge its scope to include patients irreversibly ill but not clearly dying. Patients so classified would be called "hopelessly ill" and, hence, candidates for withholding treatment.[4] This population of "hopelessly ill" would be created by delineating five subcategories of patients: (1) competent patients who refuse treatment; (2) brain-dead patients; (3) persons in persistent vegetative states; (4) the severly and irreversably demented and (5) persons with mild dementias who, they urge, be treated "sparingly".[5] Observers familiar with medical practice will note that the first three categories break no new medical ground since the first two are widely incorporated into state law and the third, persistent vegatative sates, is a condition where many physicians would recommend withholding treatment albeit at some legal risk. Turning then to numbers (4) and (5), the issue seemingly changes from a codification of current practice to something glaringly different which, if practiced today, is nonetheless clearly outside the scope of approved medical standards of care.

Gerontologists (and others) may wish to offer a number of criticisms of what is proposed, beginning with the obvious changes in societal

value-positions about terminating life. But, aside from value questions, several major criticisms can be made drawing on medical literature. First, in designating demented patients as hopelessly ill, Wanzer et al seem to assume a certainty of clinical judgment about the diagnosis of dementia that is far from apparent to observers.[6-7] Second, the same can be said for their decision to make terminal illness a major category descriptor since many clinicians, including the Presidents' Commission . . . . see terminal illness as a term too vague to be of more than marginal utility.[8-10] Third, one prominent clinician has questioned whether our society is ready to face the issue of withdrawing support to designated groups of patients[11] and finally, despite the authors' well-intentioned insistence on "high degress of clinicial certainty" and "reliabilty of diagnosis", one wonders about their somewhat uptopian view of chronically ill elderly since the problem in most long term care facilities is getting minimally adequate diagnosis and care, particularly for incompetent patients.

In light of those criticisms, it is important to add that Wanzer et al note that their purpose is also to promote debate and it is here that they may perform a valuable service if the public, and the health care industry in particular, seize this chance to focus public attention on the current uncertainty of diagnosis and prognosis of chronically ill elderly patients in an era in which costs are of major concern. While some physicians may continue to insist that "each case is decided on its own merits" (increasingly unconvincing given prospective payment regulations), sociologists are familiar with the bureaucratic principle that bureaucracies inevitably process their clients by processing categories

like those proposed by Wanzer et al and, given the increasing corporatization of medicine,[12] there seems little ground to expect that the health care industry will be an exception. Further, aside from bureaucractic principles, the fact exists that seriously ill, debilitated elderly do pose major treatment problems for even concerned physicians. Commenting on this physician dilemma, Hilficker notes that the lack of public discussion of the problem is, in part, responsible for the covert nature of end-of-life decisions,[13] a situation which Wanzer et al purport to make a matter of public debate.

This paper now turns to two major questions which should be considered in any public debate over treatement policies to sick elderly, i.e., the determination of competence in the sick elderly and, where incompetence is present, what is to be the role of families. Perhaps the most important contribution that gerontologists can make involves insisting on guidelines that enable the sick elderly to control their own futures if they choose to do so. Here the investigation of medical practices that assume the sick elderly are not capable of choice seemingly occupies a high place on a debate agenda. Today many decisions about treatment, competency and designation of surrogates take place in emergency situations and tend to be governed by what health-care providers identify as the "best interests of the patient", a determination that seems to coincide with the intertests of health-care providers. Given the growth of corporate medicine and hospital concerns to cut costs, the traditional commitment of the physician to his/her patient is endangered by what Zawicki describes as the pressure to have physicians wear "bureaucratic hats".[14] Such pressures, when coupled with the ability of hospitals to persuade,

suggests that only a determined effort by patient advocates will maintain patient autonomy. Nothing said here should be taken to mean that cost-containment strategies are unwarranted or that, at times, health care system interests should not prevail over individual patient choices but rather that it is important to bring to public scrutiny those situations where community rather than individual interests seem to prevail.

Assuming that lines can be drawn between community and individual interests (and that health care practices actually reflect a community or societal consensus, a debatable presumption), the question of which interests prevail in a given case is made more complicated by the attitudes of the health care system toward the families of patients. When hospital guidelines note that treatment modalities for the very sick patient must be in the best interest of families (e.g., do not resuscitate orders,)[15] or where guidelines claim that families do not always separate family interests from those of patients,[16] observers may wonder whether the health care system understands the critical dilemma of caregiving to the aged, that there are always competing needs to be weighed from the family's perspective. Given our current confusion about what children owe their aging parents[17] a reasonable provision in policy guidelines for treatment of sick elderly might well specify that families will, at times, have to accept treatment decisions with which they disagree, just as they have to accept other bureaucratic decisions about aged relatives. But, while it is reasonable to accept health care system decisions about what is in the "best interests of the patient", guidelines which specify "consulting" with the family seem mainly to open the door for treatment decisions where the various interests are camouflaged under

a "best interest of patient" criterion. Since gerontologists are familiar with bureaucratic procedures which dictate "best interests" of clients, this experience can be usefully employed in probing the motives of the health care system when it considers nontreatment guidelines for aged patients. But, at the same time, gerontologists should not be surprised that this same camouflaging of motives occurs when dealing with "undue" prolonging of life. If future policy guidelines are based on a clear recognition of possible differences between community, provider, patient and family interests, then treatment decisions will then be made in such a way that a reasonable weighing of interests can occur. But before this can occur, the health care system might wisely reassess its tendencies toward paternalism, where the weighing of conflicting interests is hidden behind a "best interest of the patient" wall.

This paper has concentrated on the technical consideration of nontreatment policies and has not addressed the obvious value questions which must be answered. How gerontologists should approach the value questions is beyond the scope of this paper and probably is a matter for considerable debate within gerontology. What this paper attempts is an explication of the disagreements about technical matters that are largely ignored by proposals for nontreatment policies and suggests that consideration of such policies offer fertile ground for involvement by gerontologists who are professionally involved in the fate of the very sick aged.

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